PRIOR APPROVAL FOR SERVICES

What is Prior Approval and what Services Require Prior Approval?

Prior approval is a review process that helps WVCHIP determine whether services are medically necessary and covered under its benefit plan. It also helps determine WVCHIP and its members' financial responsibility for payment of medical services. WVCHIP requires prior approval for ALL services provided outside the state of West Virginia (regardless of in-network or out-of-network status) as outlined in your Summary Plan Description (SPD). Financial responsibilities are also outlined in your SPD. Prior approval is not required for office visits to primary care doctors (family & general medicine doctors, internists, and pediatricians) in counties bordering WV in surrounding states or for emergency services received outside the state of West Virginia.

What Happens When I fail to obtain prior approval when required?

Failure to get prior approval for out-of-state services may leave you financially responsible for 100% of payment due the provider. See the Summary Plan Description (SPD) at www.wvchip.org, pages 15-16.

What is my financial responsibility when I receive prior approval for services?

Prior approval assures the services you seek out-of-state are covered benefits and will be paid by WVCHIP. Your financial responsibility will be limited to your applicable copayment.

What is the provider network?

The provider network consists of West Virginia providers who accept WVCHIP's reimbursement, and out-of-state providers who contract with Aetna Signature Administrators (ASA) PPO. Also, Wells Fargo TPA contracts directly with some providers in counties that border West Virginia. These providers are a part of WVCHIP's provider network. Please refer to your SPD for more information.

When is Prior Approval Granted?

Prior approval will be granted for out-of-state medical care or services that are NOT available within West Virginia within a reasonably accessible geographic area, or for medical conditions that require services that are not readily available within the state. If care by an equivalent specialist in West Virginia is available within a reasonable geographic range, prior approval will NOT be granted. Prior approval is NOT granted based solely on your personal preference for an out-of-state or out-of-network provider due to a perception that the local provider is not of the same quality as the physician you are requesting. You may access care from the provider of your choice, however, your financial responsibility will be considerably higher.

How do I get out-of-state services prior approved?

Complete the form on the following page and either mail or fax it to ActiveHealth. A separate form must be completed for each provider (doctor, clinic, hospital, etc.) from whom you seek services.

Mail this form to:	**ActiveHealth** **PO Box 221138** **Chantilly, VA 20153-1138**	**OR**	**fax this form to:**	**ActiveHealth** **1-866-938-0353**

How long does a typical prior approval request take?

A typical request will take about ten days to complete. If complete medical information is not provided and additional research is necessary, the evaluation of your request by ActiveHealth may take four to six weeks. You will receive written notification regarding this request. If your provider considers the situation to be medically urgent, an expedited process may be implemented at ActiveHealth's discretion.

Providing Incomplete information on this form may delay this request

REQUEST FOR PRIOR APPROVAL OF SERVICES:

Employee/Guardian Name:

_____

Street Address:

_____

City: _____ State: _____ Zip: _____

Home Telephone: _____ Work Telephone: _____

Member ID#: _____ Effective Date of Coverage: _____

(For WVCHIP this is the child's ID)

Patient Name: _____ Relationship to Employee/Guardian: _____

Referring Physician: _____ Telephone: _____

Address/City/State/Zip: _____

Services Requested for Approval and Reason for Request (please include a description of the proposed services and the specific reason(s) for care being requested, including past treatment done if applicable):

_____

_____

_____

_____

Provider being requested for approval: _____

Specialty:_____ Telephone: _____

Address/City/State/Zip: _____

Facility being requested for approval:_____

Address/City/State/Zip: _____

Date of Appointment or Procedure (if scheduled): _____

Please complete this section to allow ActiveHealth to obtain information for processing of request and/or claims.

Authorization to Release Information:

I authorize _____

(Provider's Name)

_____

(Provider's Address/City/State/Zip)

to release to ActiveHealth all information relating to past, present, and future health care examinations, conditions, and treatments for: _____

_____

(Brief Description of Medical Condition)

By signing below, I am requesting prior approval for the provider, facility, and services listed on the front of this form and I am authorizing release of information for the provider noted above. I have read and understand the attached information regarding the prior approval process.

Patient's Signature:_____ Date:_____**

**** If patient is younger than 18 years of age, the employee/legal guardian must sign this form to authorize the release of legal information.**

Employee/Guardian Signature: _____ Date: _____

Providing Incomplete information on this form may delay this request